Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:	MFDR Tracking #: M4-09-9430-01
JOHN TAYLOR, D.C. 6660 AIRLINE DR. HOUSTON, TX. 77076	
Respondent Name and Box #:	
Metropolitan Transit Authority Rep. Box # 19	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary taken from the Table of Disputed Services: "Our facility obtained pre-authorization for these services;…."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - $38.18
3. CMS 1500s
4. EOBs
5. Pre-authorization letter
6. Therapy record

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "…The bike is a group exercise and is not supported as a reimbursable charge…."

Principle Documentation:

1. Response to DWC 60
2. EOB
3. PLN-11 forms

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Denial Codes	Part V Reference	Amount Ordered
8-9-08	97110	151 & W4	1,2,3,4,5,& 6	$38.18
Total Due:				$38.18

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.203, titled *Medical Fee Guideline for Professional Services* effective for professional medical services provided on or after March 1, 2008, set out the reimbursement guidelines.

1. This service was reduced/denied by the Respondent with reason codes "151" (payment adjusted because the payer deems the information submitted does not support this many services) and "W4" (no additional reimbursement allowed after review of appeal/reconsideration).
2. A review of the CMS 1500 form identifies that four units of code 97110 was originally billed and the carrier reimbursed three of those units; denying the fourth one as 'not supported'.
3. A review of the therapy recode submitted for this DOS identifies that four units of the therapeutic exercise code 97110 was performed on this day; therefore, reimbursement for the additional/fourth unit is recommended for payment in accordance with Rule 134.203 (b) and (c) (1).
   - 97110: $52.83 divided by 38.087 x $27.53=$38.19
4. Further review of the carrier's position states that "…5 minute bike ride does not quality {sp} @ 97110 for 15 minutes…." The therapy record submitted indicates that a 5 minute bike ride/group exercise was performed and coded as '97150', which the Requestor did not bill for.
5. Per review of Box 32 on the CMS-1500, zip code 77076 is located in Harris County. The maximum reimbursement amount, under Rule 134.203 (b), is determined by locality.
6. Per Rule 134.203 (h), 'when there is no negotiated or contracted amount that complies with Labor Code §413.011 reimbursement shall be the least of the: (1) MAR amount; (2) health care provider's usual and customary charge; or (3) fair and reasonable amount consistent with the standards of §134.1 of this title.' The lesser of these three amounts was: provider's usual and customary charge.

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PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section 413.011(a-d), Section 413.031 and Section 413.0311
28 Texas Administrative Code, Rules 134.1, 134.203
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to additional reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $38.18 plus applicable accrued interest per Division Rule 134.130, due within 30 days of receipt of this Order.

ORDER:

Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.